

## **Clinical Policy: Sarilumab (Kevzara)**

Reference Number: CP.PHAR.346

Effective Date: 07.18.17

Last Review Date: 11.18

Line of Business: Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Sarilumab (Kevzara<sup>®</sup>) is an interleukin-6 (IL-6) receptor antagonist.

### **FDA Approved Indication(s)**

Kevzara is indicated for treatment of adult patients with moderately to severely active rheumatoid arthritis (RA) who have had an inadequate response or intolerance to one or more disease-modifying antirheumatic drugs (DMARDs).

### **Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Kevzara is **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Rheumatoid Arthritis** (must meet all):

1. Diagnosis of RA;
2. Prescribed by or in consultation with a rheumatologist;
3. Age  $\geq$  18 years;
4. Member meets one of the following (a or b):
  - a. Failure of a  $\geq$  3 consecutive month trial of methotrexate (MTX) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effect are experienced;
  - b. If intolerance or contraindication to MTX (*see Appendix D*), failure of a  $\geq$  3 consecutive month trial of at least ONE conventional DMARD (e.g., sulfasalazine, leflunomide, hydroxychloroquine) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effect are experienced;
5. Failure of etanercept (*Enbrel<sup>®</sup> is preferred*) and adalimumab (*Humira<sup>®</sup> is preferred*), each used for  $\geq$  3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced;  
*\*Prior authorization is required for etanercept and adalimumab.*
6. Dose does not exceed 200 mg every two weeks.

**Approval duration: 6 months**

##### **B. Other diagnoses/indications**

1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

**II. Continued Therapy**

**A. Rheumatoid Arthritis** (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 200 mg every two weeks.

**Approval duration: 12 months**

**B. Other diagnoses/indications** (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

**Approval duration: Duration of request or 6 months (whichever is less);** or

2. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A.** Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

DMARD: disease-modifying  
antirheumatic drug

FDA: Food and Drug Administration

IL-6: interleukin-6

MTX: methotrexate

RA: rheumatoid arthritis

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

<b>Drug Name</b>	<b>Dosing Regimen</b>	<b>Dose Limit/ Maximum Dose</b>
azathioprine (Azasan <sup>®</sup> , Imuran <sup>®</sup> )	<b>RA</b> 1 mg/kg/day PO QD or divided BID	2.5 mg/kg/day
Cuprimine <sup>®</sup> (d-penicillamine)	<b>RA*</b> <u>Initial dose:</u> 125 or 250 mg PO QD <u>Maintenance dose:</u> 500 – 750 mg/day PO QD	1,500 mg/day
cyclosporine (Sandimmune <sup>®</sup> , Neoral <sup>®</sup> )	<b>RA</b> 2.5 – 4 mg/kg/day PO divided BID	4 mg/kg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
hydroxychloroquine (Plaquenil <sup>®</sup> )	<b>RA*</b> <u>Initial dose:</u> 400 – 600 mg/day PO QD <u>Maintenance dose:</u> 200 – 400 mg/day PO QD	600 mg/day
leflunomide (Arava <sup>®</sup> )	<b>RA</b> 100 mg PO QD for 3 days, then 20 mg PO QD	20 mg/day
methotrexate (Rheumatrex <sup>®</sup> )	<b>RA</b> 7.5 mg/week PO, SC, or IM or 2.5 mg PO Q12 hr for 3 doses/week	30 mg/week
Ridaura <sup>®</sup> (auranofin)	<b>RA</b> 6 mg PO QD or 3 mg PO BID	9 mg/day (3 mg TID)
sulfasalazine (Azulfidine <sup>®</sup> )	<b>RA</b> 2 g/day PO in divided doses	3 g/day
Enbrel <sup>®</sup> (etanercept)	<b>RA</b> 25 mg SC twice weekly or 50 mg SC once weekly	50 mg/week
Humira <sup>®</sup> (adalimumab)	<b>RA</b> 40 mg SC every other week (may increase to once weekly)	40 mg/week

*Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.*

*\*Off-label*

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): known hypersensitivity to sarilumab or any of the inactive ingredients
- Boxed warning(s): risk of serious infections

*Appendix D: General Information*

- Definition of MTX or DMARD Failure
  - Child-bearing age is not considered a contraindication for use of MTX. Each drug has risks in pregnancy. An educated patient and family planning would allow use of MTX in patients who have no intention of immediate pregnancy.
  - Social use of alcohol is not considered a contraindication for use of MTX. MTX may only be contraindicated if patients choose to drink over 14 units of alcohol per week. However, excessive alcohol drinking can lead to worsening of the condition, so patients who are serious about clinical response to therapy should refrain from excessive alcohol consumption.
- Examples of positive response to therapy may include, but are not limited to:
  - Reduction in joint pain/swelling/tenderness
  - Improvement in ESR/CRP levels

- Improvements in activities of daily living

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
RA	200 mg SC once every two weeks	200 mg every 2 weeks

**VI. Product Availability**

Single-dose prefilled syringe/pen: 150 mg/1.14 mL, 200 mg/1.14 mL

**VII. References**

1. Kevzara Prescribing Information. Bridgewater, NJ: Sanofi-Aventis U.S. LLC; April 2018. Available at: <https://www.kevzara.com/>. Accessed February 27, 2018.
2. Singh JA., Saag KG, Bridges SL, et al. 2015 American College of Rheumatology guideline for the treatment of rheumatoid arthritis. *Arthritis Care & Research*, 68: 1–25. doi:10.1002/acr.22783.
3. Aletaha D, Neogi T, Silman AJ et al. 2010 Rheumatoid Arthritis Classification Criteria. *Arthritis and Rheumatism* September 2010;62(9):2569-2581.
4. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2018. Available at: <http://www.clinicalpharmacology-ip.com/>.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	06.17	11.17
2Q 2018 annual review: removed TB testing requirement; references reviewed and updated.	02.27.18	05.18
4Q 2018 annual review: no significant changes; references reviewed and updated.	09.04.18	11.18

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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**Note:**

**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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